ScotPHN report

Scottish Public Health Network (ScotPHN)

Shared Public Health Priorities for Scotland

ScotPHN Engagement Events: Final Report

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Contents

Introduction

Establishing shared public health priorities for Scotland is one of the three public health reforms described in the Scottish Government's Health and Social Care Delivery Plan (published in December 2016), alongside the creation of a new national public health body, in 2019,and enabling a joined-up approach to public health at local level.

The format of these events provided a background to reform and the rationale for carrying out engagement on the priorities. Marion Bain and Eibhlin McHugh, Co-Directors of the Executive Delivery Group for Public Health Reform, presented how agreeing priorities for public health is a key element of current public health reform given the continued challenges to Scotland's health and widening health inequalities, and the need for cross partnership working to address these. And so the participants were asked to be ambitious in developing these.

Representatives of the Expert Group (Colin Sumpter, Peter Seaman, Gerry McCartney, John Frank) provided an overview of the Evaluation Framework and Criteria the group had developed as part of the process for developing and judging potential priorities. They did not present their own suggested priorities as the purpose of these events was to provide participants the opportunity to suggest their own, informed by their experiences of public health.

Following presentations, the participants undertook two facilitated workshop discussions in multi-disciplinary, multi-organisational groups. This format was intended to ensure that a range of views could be expressed that would help inform discussions and reflect the desire for partnership working.

- Workshop 1

Each group was asked to discuss the criteria developed by the Expert Group and make any amendments they thought necessary and capture the reasons for this. They were also asked to develop an initial, 'long' list of potential priorities.

- Workshop 2

Using the criteria agreed by the group, each group was asked to review its long list of potential priorities and choose their final set of priorities. These were to be ranked and the rationale for each choice recorded. Not all groups chose or had time to rank their chosen priorities.

- Car Parks

Any views that participants felt had not been addressed in the workshop discussion, could be posted in the ‘car park’ and would be addressed out with the events. Any subsequent comments or submissions which were made after the engagement events have been included as part of the “car park” data.

The outputs from each workshop and the ‘car park’ have been collated and analysed to identify key points and/or emergent themes. An analysis of the engagement and communication in support of the discussions has also been undertaken. Each area was analysed by an individual author using a method appropriate to the data created by the workshop or activity. These analyses are presented as separate sections of this report, with the method used briefly described and the main themes and issues outlined. The benefit of taking this approach has been to allow each section to be read as individual pieces.

Analysis of Workshop 1

Participants at all the engagement events were given the opportunity to reflect and comment on the Evaluation Framework and Prioritisation Criteria ("the Framework") developed by the expert working group. The criteria within the framework were developed through review of existing literature on priority setting and discussions amongst the expert group to facilitate the identification of potential public health priorities.

The objective of the facilitated discussion within workshop 1 was to obtain the views of multi-disciplinary, multi-agency groups on the Framework. During the workshop participants were asked to discuss the Framework's content and propose any amendments they would suggest to help improve and strengthen it. Specifically the group was asked to consider:

- are these the right criteria?
- which are most important? and
- what amendments would you suggest?

All groups were asked to provide their feedback using a standard pro-forma.

The responses to workshop 1 – both completed pro-forma returns and additional free text comments – were analysed in two ways. Firstly, feedback was pooled under a number of emerging themes from workshop 1 discussions. The analysis of these data are summarised below:

- General support for the approach taken and the use of a criteria-based method of identifying public health issues significant enough to be considered 'priorities';

- Some concerns relating to the approach taken included:
    - a sense that this was not 'different enough'; that there is a need for infrastructure change to facilitate cross fertilization of policy and public health action;
    - a request that wording be more carefully considered and definitions of key terms (e.g. 'public', 'public health') be included;
    - concern that this type of approach is perhaps not sensitive enough to capture the interconnected nature of many public health issues;

- A degree of uncertainty about the purpose of the public health priorities for Scotland: *how will they be used and by whom?*; *what happens to work streams which are not considered a priority?; are these to be short or long term priorities, similarly, are they to be reflective of the current public health*

landscape or be more future-facing?; *how will progress against chosen priorities be measured and over what timeframe?*

- Discussion about the difference between transformational priorities and those more likely to result in incremental change; suggestion that different criteria would be required to select these two types of public health priority;

- Concern that the criteria were most useful for developing priorities within health improvement and perhaps did not reflect the breadth of public health work;

- While participants were not specifically asked to weight the criteria, many groups indicated that this would be an important part using a prioritisation tool such as this. However, the process of weighting the criteria appeared to be challenging for some groups. Many chose to identify the criteria which they felt best differentiated between various public health issues and use these to rank priorities. Several groups commented that the criteria needed to be weighted but did not appear to begin to do this within the workshop;

- A strong sense that the criteria in sections 1 and 2 were more useful in identifying and setting priorities than those in section 3. Some groups did not weight/score priorities against section 3 criteria;

- Many groups identified the potential impact of disinvestment (criteria 1.3) as an important prioritisation criteria during their workshop discussions, though it appeared that this was not carried through to selection and ranking of priorities in workshop 2;

- The importance of community engagement was highlighted across all stakeholder events. Participants in the virtual event in particular raised the need for the criteria to be flexible enough to ensure the differing needs of urban and rural populations could be considered;

- Several groups felt that the importance of themes such as ethics, human rights and health inequalities were not adequately brought out in the existing criteria and suggested that an additional point be added to section 2 to reflect this.

- During the workshop groups considered the usefulness of the criterion relating to the importance of a priority to ‘local government’. No separation was made between formal integration bodies (such as Integrated Joint Boards), or the Community Planning Partnership mechanisms. For some participants there was a feeling that the priorities could not be limited to the

work of the Integrated Joint Boards alone and needed to reflect the fuller range of public health priorities. Such comments did, however, reflect differing local arrangements.

On further analysis of the comments received, it has been possible to provide a summary of the amendments to the criteria that were proposed across the four stakeholder engagement events. This is shown in table 1.

Table 1: Comments and Proposed Amendments to Evidence-based Criteria for Choosing Scotland's Public Health Priorities

Headline Question	**Sub-question**	***Comments / Amendments / Feedback***
1. Is this priority addressing an important public health concern?	1.1 What is the current 'size' of the problem?	• *lots of comments regarding the definition of 'size' – scale / impact / scope / magnitude / severity all suggested alternatives*
	1.2 How has the problem changed and how might it change in the future?	• *has the problem changed as the result of a significant event; is this change a positive or negative* • *'problem' must be inclusive of services, not just behaviours; i.e. services and systems* • *'how has it changed over time and how might it change in the future'*
	1.3 What would happen if we disinvested in this area?	• *do we have any assets to support what we currently do* • *what is the cost of doing nothing* • *change 'disinvestment' to 'adverse consequences of not investing'* • *what are the long term consequences* • *some suggestion that this does not allow us to capture what we are currently doing well*
	1.4 What are the wider impacts?	• *for whom?* • *issues of interconnected-ness / cross policy impact* • *need to include ethical, fairness, rights and equalities impacts*
2. Can we do something about it? *Who is 'we' on section 2 and 3?*	2.1 Is this issue amenable to prevention by known effective measures?	• *opportunity cost / cost effectiveness / outcome vs cost* • *lots of discussion of this criteria as a quantifiable marker* • *'management' , 'mitigation' or 'effective change' rather than 'prevention' – improvement is broader than prevention*
	2.2 Are the measures cost efficient?	• *How can this be assessed/measured in practice* • *'are measures cost effective to individuals, public services, wider society'*
	2.3 Does this priority impact health inequalities, or risk	***This was identified as a key criterion*** • *to remove 'or risk worsening them'*

	worsening them?	
	2.4 When might we expect to see results?	• *acknowledgement of lengthy time scales* • *are timescales political, social, medical?* • *'results' vs. 'benefits'*
	2.5 Is there scope for innovation on this priority?	• *general feeling that this is unimportant and could potentially be removed*
	2.6 How can communities be empowered through this priority?	***This was identified as a key criterion*** • *importance of 'bottom-up', community engagement approach was strongly emphasised*
3. Do we want to do something about it? *Some commented that these are implicit in the approach and therefore not required*	3.1 Do the public prioritise this issue?	• *before 'do the public prioritise this' – 'are the public aware of this issue?'* • *differing priorities by geographical area – rurality* • *who are the 'public' in this context; how are they different from the 'communities' in 2.6*
	3.2 Do local government prioritise this issue?	• *national vs local priorities*
	3.3 Do the professions who will likely work on this prioritise this issue?	
	3.4 Does the Scottish Government share the aims of this priority?	
	3.5 Is this issue best addressed by a joined-up approach rather than lying mostly with one agency?	• *some identified this a key criterion BUT others felt that this was implicit in all priorities therefore not a useful differentiator?*

Analysis of Workshop 2

In the second workshop, participants were asked to use the Framework they had revised to prioritise the long list of public health challenges they had identified into a shorter list. No upper limit for the number of priorities that could be set was provided, but the pro-forma used only provided for ten priorities. As in workshop 1, participants were asked to provide a rationale for the selection of a public health priority.

Two critical questions were addressed for the analysis: 1) what were the most highly ranked priorities across the engagement; and 2) what wording was used to describe these priorities.

Data from the all three events in Edinburgh, Aberdeen and Glasgow and the virtual events have been included in the analysis.

Priority ranking: Analysis approach

The individual short list of priorities from each of the tables was transcribed to obtain an overall list of headline priorities chosen on a table by table basis. Where a table had identified a 'composite' priority – one that encompassed more than a single issue or challenge – it was broken down into individual priorities. Where this was not clear, the rationale provided for the priorities inclusion was used to help understand the intended priorities. Priorities were then mapped or grouped to a smaller number of broad priority themes.

The list of priorities was then ranked in three ways:

1. *Ten points per table:* In this method each table was allocated a maximum of 10 points which were then split between the lists of individual priorities for that table. So on a table with 10 priorities, each would be allocated 1 point, or on a table with 4 priorities, each would be allocated 2.5 points. For a given priority the total number of points allocated across all the tables was calculated and then placed in rank order of the points.

2. *One point per priority*: In this method each individual priority was simply awarded a point. As before, the total number of points allocated to given priorities was calculated and then placed in rank order of the points.

3. *Weighted by order*: In this method the priorities ranked more highly by tables were given more of the ten points per table than lower ranked priorities at a ratio of 2:1 highest ranked: lowest ranked regardless of the total number of priorities. Ranking by this method was only possible for 30 / 40 tables, (75%), as table ranking was explicitly

rejected by some tables. Were a table had not been able, or refused, to rank priorities the ten points were distributed equally.

None of these three approaches is considered to be superior to the others; they are all provided to allow assessment of the impact of each on the overall rankings of different scoring approaches. As with the engagement as a whole this is not meant to be a strictly quantitative approach and qualitative judgement is required, both in the grouping of priorities for analysis, and in reading of the results.

Priority wording: Analysis approach

The full wording of the priorities was then reviewed under each broad heading to better understand the desired focus of the priority. Analysed ‘elements’ within each, one priority could include more than one element e.g. a priority worded ‘diet, obesity and physical activity’ would constitute three elements: ‘diet’, ‘obesity’ and ‘physical activity’.

Wrote a simple scoring and qualitative summary of people’s preferred wording. Links to the policy and professional context are provided where known.

Priority ranking: Findings

Table 2 provides the final ranking of individual priorities by the three methods. The point scores provide an indication of the level of separation between each rank, the rankings provide the order.

There are some natural breaks in the top ten priorities with two clearly dominant priorities (mental health and wellbeing; and poverty and inequality) followed by a fairly steady decrease in preference across the remaining priorities. The top eleven priorities, plus thematically related lower priorities, were taken forward for further analysis in terms of priority wording.

There are judgements to be made in the extent to which we combine or separate out priorities and this is discussed further in the ‘priority wording’ findings section.

Table 2: Individual Rankings of Priorities

	1: 10 points per table	Rank	2: One point per priority	Rank	3: Weighted	Rank
Mental Health and Wellbeing	378	1	310	2	426	1
Poverty and inequality	371	2	320	1	425	2
Early Years (including Adverse Childhood Experiences)	303	3	260	3	337	3
Diet and Obesity	300	4	260	3	271	5
Housing	267	5	220	5	273	4
Physical activity	235	6	210	6	242	6
Alcohol	222	7	210	6	219	7
Built environment and Place	208	8	190	8	212	8
Work and Education	177	9	150	9	176	9
Improve Public Services	145	10	130	10	136	11
Power / Community empowerment / development	137	11	130	10	140	10
Social isolation	129	12	110	13	115	12
Tobacco / smoking	107	13	120	12	106	13
Climate Change	102	14	80	15	87	15
Drugs	97	15	100	14	89	14
Health protection	90	16	80	15	78	17
Transport	74	17	50	19	82	16
Older people / Healthy ageing	70	18	80	15	62	18
Environmental Health / Air pollution	55	19	60	18	46	20
Vulnerable Groups / Stigma / Exclusion	51	20	40	21	41	21
Green space	49	21	50	19	49	19
Remote and rural health	41	22	30	24	34	22
Screening	33	23	40	21	30	23
Vaccination and Immunisation	32	24	40	21	29	24
Unintentional injuries	28	25	20	26	22	28
Health Intelligence / Technology	27	26	30	24	25	25
Controlling and managing chronic conditions	26	27	20	26	23	27
Violence and abuse	23	28	20	26	24	26
Sexual health and relationships	17	29	20	26	19	29
Antibiotic Resistance	17	30	20	26	14	31
Cancer	13	31	10	31	14	30
Dental	9	32	10	31	6	36
Health and safety at work	8	33	10	31	6	35
Leadership	8	33	10	31	11	32
Fuel poverty	8	33	10	31	7	34
Blood Borne Viruses	7	36	10	31	7	33

Priority wording: Findings

- Mental Health and Wellbeing

This proved to be a closely worded priority with little variation across tables. The majority favoured 'Mental health and wellbeing' with a small number varying from this to focus on one concept or the other. A minority included resilience.

A linked policy element is the *Mental Health strategy for Scotland*.

Elements	Count
Mental health and wellbeing	12
Mental health	10
Mental wellbeing	9
Resilience	6

Total mentions: 31. Ranking: 1st overall

- Poverty and inequality

Two closely linked elements dominated this priority: poverty and inequality. Based on the rationales given and priority wording when participants talked about inequality they overwhelmingly focused on income inequality so these concepts were grouped.

Surprisingly few chose the term 'health inequalities' possibly as this would be considered an overarching priority, but this is an assumption. There were a minority of mentions of other forms of inequality in health outcomes including vulnerable groups.

There may be a significant challenge in closely defining what we mean by this priority in a public health context.

A linked policy element is the *Poverty and Inequality Commission* and the *Fairer Scotland Action Plan*. This wording is in common usage in Government and professional circles.

Elements	Count
Poverty	17
Inequalities	6
Income inequality	5

Total mentions: 32. Ranking: 2nd overall

- Early Years (including Adverse Childhood Experiences)

The core question on this priority is whether to combine early years with adverse childhood experiences, or to separate them. If separated, they would clearly have ranked lower, but both would still be prominent themes. Adverse Childhood Experiences (ACEs) were mentioned, or the main focus, in 7 out of 26 early year's priorities. The term 'early years' was preferred to young people, children or any other. Families and parenting were included by a minority.

At the beginning of this priority setting process there was reluctance to focus specifically on population groups, but rather on the problems faced by them i.e. focus on obesity across the age groups if a priority, rather than focus on the issues faced by young people specifically. However this population group has come out strongly from the engagement as a priority, as has 'poverty'. Older people is the only other population group mentioned in the long list, and far less frequently.

Elements	Count
Early years	18
ACEs	7
Families / parenting	4
Best start in life	2

Total mentions: 26. Ranking: 3rd overall

- Diet and Obesity

Weight is an issue of energy consumption and expenditure. However, few people in the engagement combined these two issues instead predominantly choosing to focus on the concept of 'diet' or 'nutrition'.

It was more common to say 'obesity' than 'healthy weight', arguably a negative framing of the issue but apparently more clearly understood by the professionals involved in the engagement. There was no mention of BMI. A minority focused on the environment or the role of industry in human weight but these could be considered to be approaches rather than problem frames.

A related policy is the *Diet and Obesity Strategy* and repeating this wording would be clear alignment.

Elements	Count
Obesity (any mention)	12
Obesity (alone)	5
Diet	7
Nutrition	6
Healthy Weight	2
Food / obeso-genic environment	2
Unhealthy commodities / marketed hazards	2

Total mentions: 26. Ranking: 4th overall

- Place

Three ‘place’ related priorities all scored highly: Housing and homelessness (5th); built environment (8th); community empowerment (10th); and (to a lesser extent) green space. Combined they score even more highly. There was a great deal of overlap and it is not simple to quantitatively extract the relative importance of these from each other. Arguably ‘social inclusion’ (12th) could also be included here.

The key issue is whether it is beneficial to combine housing, the rest of the physical environment (e.g. infrastructure, commercial environment, green space) and general community wellbeing into a single priority (possibly named ‘Place’), whether they are better dealt with as single issues, or something in between.

In the analysis housing was the dominant element in the ‘Place’ mix. 7 out of 19 built environment priorities also specifically contained housing in their wording. More have included it in their rationale for inclusion.

There was some debate during the criteria development process as to the conflation of housing and homelessness as a single issue and the group concluded that this was the best way forward on this priority in their long-list.

Health Scotland describe place as the buildings, streets, public spaces and natural spaces that make up the physical environment of neighbourhoods, and communities as the relationships, social contact and support networks that make up the social environment of neighbourhoods. The communities element has therefore been included.

The word cloud below indicates which terms were dominant in all priorities included under the four groupings: housing; built environment and place; green space; and power, community power and community development.

- Physical activity

This priority was dominated by the single issue wording ‘physical activity’ with no additions. A minority preferred the negative frame of physical inactivity. As mentioned a minority combined the physical activity element with diet, obesity, physical environment or active travel. Sport was not mentioned by anyone.

Element	Count
Physical activity / inactivity (only)	13
Active travel	2
Physical activity and built environment	2
Diet, obesity and activity	1
Green space and physical activity	1

Total mentions: 21. Ranking: 6th overall

- Alcohol (or wider substance misuse)

The key issue with this priority is whether to include drugs other than alcohol including tobacco in the priority. There were 29 individual priorities that included reference to alcohol, tobacco or drugs. These added up to 43 elements (single mentions within priorities) as many overlapped with terms such as ‘substance misuse’ or ‘addictive behaviours’. The rationales were assessed and the level of overlap was determined as shown in the diagram below. In addition 4 priorities recommended including all of tobacco, alcohol and other drugs.

Total mentions: 21. Ranking: 7th overall

- Work and education

Work and education were joined together by some choosing priorities so were analysed together. There could still be a case for dealing with each separately. Additional related priorities included health and safety at work (single mention).

The fill list of priorities is provided below ordered into those that focused primarily on work, those that focused primarily on education, and those that dealt with both.

	Element	Count
Work (8 mentions)	Employment	1
	Access to income	1
	Economic inclusion	1
	Employment and fuel poverty	1
	Good quality work	1
	Good work / employability	1
	Health and economic policy	1
	Meaningful and secure employment with reasonable pay	1
Education (4 mentions)	Education	2
	Educational opportunity	1
	Positive Destinations	1
Both (3 mentions)	Education for Change / resilience including employment	1
	Education, work and employment	1

Total mentions: 15. Ranking: 8th overall

- Improvement of public services (including healthcare)

This was again a complex and diverse over-code which contained multiple elements. These are provided in full below to allow for discussion. The two most prevalent elements were promoting a joined-up approach and access to services.

From the outset groups were steered away from priorities that focused primarily on improving public services as these were felt to be elements of the solution rather than the problem. Many of those priorities included below would appear to be 'ways of working' rather than an actionable priority.

	Priority Wording	Count
Joined-up / Partnership working (6 mentions)	Better cross-sectoral collaboration for public health	1
	Defining roles across sectors	1
	Health and care system including early detection of disease	1
	Partnership and communication	1
	Seamless service provision	1
	Siloed rather than holistic approach to people (budgets / services)	1
Access (3 mentions)	Access to services	2
	Equitable, accessible services (aligned, integrated, person-centred)	1
Health Services	Supportive sustainable health services	1
	Sustainable community health care system	1
New body	Review and monitoring (external) of new body and priorities	1
Quality	Supporting delivery of valued quality services	1

Total mentions: 13. Ranking: 9th overall

Analysis of the “Car Parks”

At each of the engagement events a “Car Park” was established. This allowed participants to record their thoughts / observations which they felt were not necessarily being discussed fully during the event, or which they felt needed to be taken into account in some way as part of the process of setting priorities.

In analysing the car park data, the individual notes were transcribed and separated out into individual comments / issues. This was important as many comments provided multiple points which needed to be disaggregated. Where a comment was posed as a question or a point of challenge, these have been expressed as questions.

Car Park comments from all four events have been included, as have additional comments from people who were unable to attend and submitted comments later.

Analysis of the individual comments was undertaken on a two stage, thematic analysis. Firstly a set of over-arching or guiding themes were identified from the responses. The analysis of guiding themes has highlighted eight areas. These were:

- specific public health issues;
- comments on the framework/criteria/priority setting;
- the future public health system;
- resourcing the public health system;
- approach to public health practice;
- the workforce;
- the wider determinants; and
- issues/challenges.

Once these were created, individual responses were allocated to the guiding themes and a second analysis was undertaken to derive emergent themes within each guiding theme. The analysis of the emergent themes relating to specific public health issues by location of event is presented in included in Table 3. The analysis of the other seven areas looks at the frequency of comments and the principle emergent themes is presented in Table 4.

Specific Public Health Issues

As shown in Table 3, from a purely quantitative basis, the most commonly identified issues were the immunisation and vaccination programme and the health of older people, both of which recorded five mentions across all events.

Table 3: Specific Public Health Issues

Edinburgh Event	Aberdeen Event	Glasgow Event	Virtual Event (& other submissions)
		Immunisation & Vaccination (3)	Older people (3)
Access to services (2)		Alcohol (2)	
Advocacy (2)		Communicable disease control (2)	
Early years (2)		Healthcare PH (2)	
Immunisation & Vaccination (2)		Housing (2)	
Obesity (2)		Mental health (2)	
Older people (2)		Physical activity (2)	
Social media use (2)			
Water quality (2)			
Alcohol	Brexit	Access to services	Active travel
Antimicrobial resistance	Mental health	Arts & Culture	Alcohol
Climate change	Rural and remote health	Childsmile	Dementia
Compassionate communities	Universities	Employment	Diabetes prevention
Diabetes prevention		Fuel poverty	Healthy eating
Disability		Healthy food	Lead poisoning
End of life care		Oral Health	Mental health
Environmental sustainability		Screening	Obesity
Healthy food		Tobacco	Physical activity
Inequality reduction		Violence prevention	Tobacco
Lead poisoning			Wellbeing
Long term conditions			
Migrant health			
Physical activity			
Prison health			
Screening			
Social isolation / loneliness			
Spiritual care			
Tobacco			
Workplace safety			

It is notable that whilst there is a breadth of issues identified across all the main domains of public health, the priorities identified do reflect more issues within the domain of health improvement rather than the health protection and healthcare quality and effectiveness domains.

Within domains, there is also a range of areas which reflect the spread of public health concerns. For example, the domain of health protection includes as possible priorities: immunisation and vaccination; communicable disease control; antimicrobial resistance; water quality; lead poisoning; and environmental sustainability. Moreover many of the areas identified can also exist in multiple domains of public health or nested within wider issues; fuel poverty can be seen as an issue with inequality reduction, but it also has a relationship to climate change adaptation.

Other Guiding and Emergent Themes

The analysis of the remaining guiding and emergent themes is summarised in Table 4.

Table 4: Other Guiding and Emergent Themes

Guiding theme	Comments by event	Emergent themes
Comments on the framework / criteria / priority setting	Edinburgh: 11 Aberdeen: 2 Glasgow: 18 Virtual: 0 ALL: 31	• Need for wider public engagement in the process • LOIPs are not suitable for priority setting • How will future priorities be set and when? • Many comments were made on the specifics of the criterion-based process BUT not that it was an inappropriate approach
The future public health system	Edinburgh: 20 Aberdeen: 5 Glasgow: 25 Virtual: 2 ALL: 52	• Able to support integration / cross-boundary working • Capable of maintaining existing Public Health gains • Provide effective leadership • Need for a system that can innovative and respond to population changes
Resourcing the public health system	Edinburgh: 6 Aberdeen: 2 Glasgow: 2 Virtual: 0 ALL: 10	• Avoid negative impacts of disinvestment due to priority change • Need for more flexible approaches to resourcing
Approach to public health practice	Edinburgh: 24 Aberdeen: 2 Glasgow: 12 Virtual: 2 ALL: 40	• Achieving meaningful knowledge in action • Person-centred PH approach • Empowering communities to become well • Action across the lifecourse • Create a system that can co-create health

The workforce	Edinburgh: 12 Aberdeen: 0 Glasgow: 4 Virtual: 2 ALL: 18	• Multi-disciplinary, multi-professional, with adequate levels of staffing • Need better engagement with 3rd sector • Need clear definition of the Public Health workforce
The wider determinants	Edinburgh: 8 Aberdeen: 3 Glasgow: 8 Virtual: 0 ALL: 19	• Role of education in health attainment • Supporting employment / employability • Building community & social capital • Challenging the influence of multinationals
Issues and challenges	Edinburgh: 14 Aberdeen: 5 Glasgow: 18 Virtual: 5 ALL: 42	• How are we to reconcile the differing sets of priorities: national v local; Government v people? • How can we ensure that people are at the heart of the priorities and delivery • Do people know what "public health" means? • Who owns the Public Health system; is this not important in identifying resources and access to them?

Across all the events, 1 in 4 of the comments related to future public health system (52/212, 24.5%), with just short of 1 in 20 relating to resources (10/212, 4.7%).

The most interesting reflection is that across all the guiding themes, the emerging areas reflect very clearly the concerns which were identified in 2015 Public Health Review relating to effective leadership, maintaining public health gains, the realities of integration and becoming more open to involving the wider workforce and involving the public we serve in the practice of public health.

Analysis of Ongoing Communication and Engagement

Throughout the Edinburgh, Aberdeen and Glasgow engagement events a Communication and Engagement specialist undertook a participant observation exercise to assess the views of delegates on the approach and quality of the engagement and to identify any future messages to feed into the wider Communication and Engagement Strategy for the overall public health reform process.

Twitter played an important role in engagement during and between the events. Participants and stakeholders unable to attend in person engaged in the conversation by using the hashtag #phpscot. There are a number of key ways to analyse the impact of Twitter activity. Most notably:

- **Impressions** (the number of times a Tweet is seen by Twitter users);

- **Engagements** (the number of times a user did something with the Tweet, i.e., retweets, likes, replies, user profile clicks, url clicks, hashtag clicks, detail expands, media views and media engagements); and

- **Twitter Engagement Rate (TER)**: the number of engagements divided by impressions (i.e., of everyone who saw the Tweet, this is the percentage of people who did something with it).

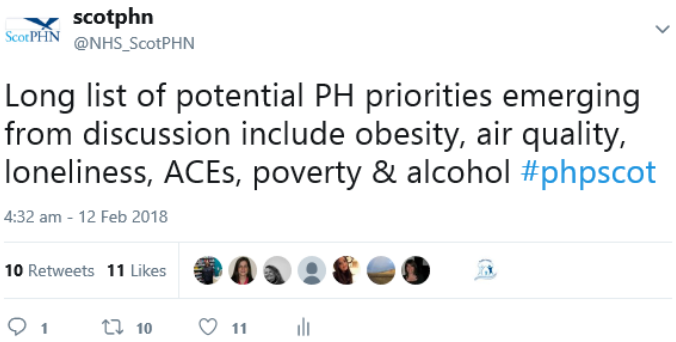
ScotPHN Tweeted 75 times from the three engagement events. This resulted in:
- 63,075 impressions;
- 1,504 engagements;
- 178 retweets; and
- 239 likes.

This created an average TER of 1.4%. This is in line with industry standards (1-2%) and – as a comparator – is above the target TER adopted by NHS Health Scotland. This vastly increased the engagement in the events beyond the approximately 370 people who attended in person.

An analysis of the overall hashtag activity is beyond the remit of the report; a separate analysis of #phpscot has been undertaken by the PHR Team. In light of the great deal of activity that was generated by the engagement events via the ScotPHN Twitter activity, ScotPHN would suggest that there would be significant potential for the Public Health Reform team to continue to use social media to engage around the priorities, and public health reform more generally, via the @PHRScot account.

Impressions: Top 5

#1



This Tweet was seen the highest number of times by Twitter users (4,763 impressions). It was also in the top five for engagements (81), retweets (10) and likes (11).

People/organisations who engaged with this Tweet included the Head of Policy and Development at Community Pharmacy Scotland, Community Food & Health Scotland and the Assistant Director of Impact - Mental Health and Wellbeing at Barnados.

Many of the people/organisations who liked and retweeted the Tweet were not at the actual event, which further emphasises the importance of social media in engaging with stakeholders.

#2

This Tweet had the second highest number of impressions (4,003). It was also in the top five for retweets (9) and the top ten for likes (9) and engagements (69).

Tweets like these are helpful, especially for stakeholders who are unable to attend the event but will follow along on Twitter. It was retweeted by a number of influential stakeholders including Marion Bain, Gerry McCartney and (although he was not at the event) Ian Welsh, the CEO of the ALLIANCE (who has over 6,000 followers).

#3

The Tweet with the third highest number of impressions (3,924) was also in the top five for engagements (90) and the top ten for retweets (8) and likes (10).

This Tweet also benefitted from being retweeted by a number of influencers with many followers who were not at the event themselves as well as some who were, including Samaritans Scotland (3,820 followers).

#4

The Tweet with the fourth highest number of impressions (3,534) was the number one Tweet for engagements (147), retweets (15) and likes (21).

This indicates the importance felt by stakeholders of tackling the social determinants of health. It was retweeted by delegates at the event, delegates at previous events (e.g., Josie Murray, Public Health Specialty Registrar - 494 followers) and also by wider stakeholders including Simon Capewell, Professor of Public Health and Policy at Liverpool University and Vice President for Policy at the Faculty of Public Health (2,808 followers). It also benefited from the reach of the GCPH Twitter account (4,168).

#5

Ranked fifth on the list with 3,288 impressions, this Tweet was ranked second for engagements (139) and retweets (13) and fourth for likes (10).

Again this was retweeted by delegates at the event such as the Head of Policy, Projects and Participation at Children in Scotland, but also by people further afield such as the Director of Public Health in Sheffield (with 5,992 followers).

Engagement rate

The three Tweets with the greatest Twitter Engagement Rate (TER) are in joint first place with a 6% TER. Two include photos with text in the background that stakeholders might have clicked on to read better. The third includes an image that people may have clicked on to read better and/or clicked on the link to access information about the Burden of Disease study.

scotphn
@NHS_ScotPHN

Following

Workshop 2 introduced by @phil_mackie Delegates to produce a ranked list of priorities along with the rationale for the top 5 #phpscot

2:19 pm - 12 Feb 2018

2 Retweets 4 Likes

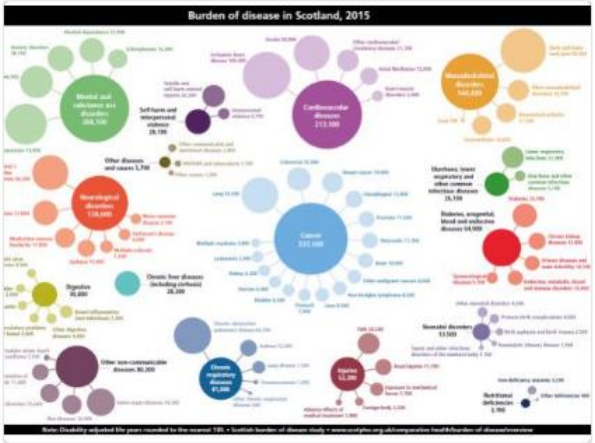
Phil Mackie

2 4

scotphn
@NHS_ScotPHN

Following

Gerry McCartney highlights the big causes of disease as a factor in prioritising scotpho.org.uk/media/1450/sbo... @gerrymccartney1 #phpscot



11:45 am - 21 Feb 2018

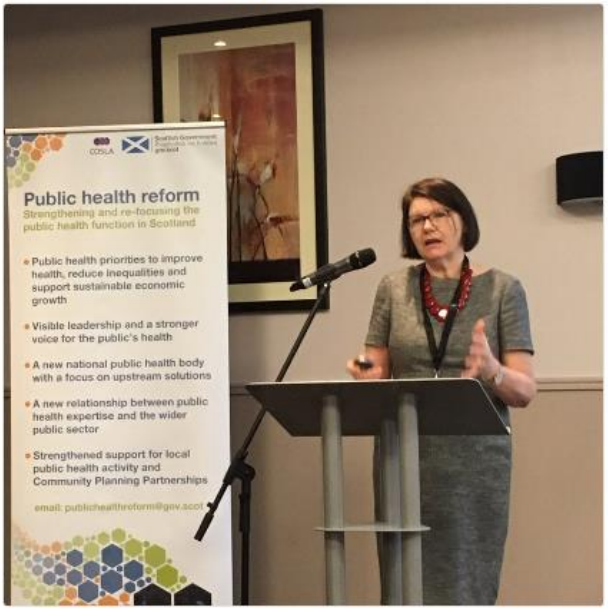
3 Retweets 4 Likes

3 4

scotphn
@NHS_ScotPHN

Following

Eibhlin McHugh says that the focus is on good health for Scotland - for the whole of the population #phpscot



11:25 am - 21 Feb 2018

2 Retweets 1 Like

2 1

Summary

The use of social media by the ScotPHN team greatly increased the reach of engagement in the Public Health Priority events in February 2018. Tens of thousands of people who were not at the events saw the Twitter activity and a number of influential stakeholders shared Tweets from the events with their followers.

This demonstrates the benefit of using social media and that the PHR Team should make on-going use of Twitter to ensure effective engagement.

Conclusions

In this report we have presented the analyses from the data collected during the three physical and one virtual engagement events carried out as part of the development of public health priorities in Scotland. Given the nature of the data and how it has been analysed, it would be inappropriate to draw too firm a set of conclusions.

However a number of common observations are possible:

1. participants did welcome the opportunity to be involved, especially within the virtual event;
2. many comments were made on the specifics of the criterion-based process BUT not that it was an inappropriate approach;
3. amongst proposed priorities, health improvement issues predominate; though the need to ensure health protection and healthcare public health activities are not “lost” was expressed and a number of key priority areas identified;
4. there is a clear eagerness to ensure that the public and their communities are engaged with, and empowered by, this and future exercises; and
5. the framing and launch of the priorities will be important in securing wider engagement and support for the public health priorities.

ScotPHN report

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